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University of Bath

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Mentally disordered offenders' views of 'their' risk assessment and management plans

Jeremy Dixon

Abstract

In Britain there has been an increased emphasis on the use of risk assessments in mental health services over the past twenty years. Mentally disordered offenders subject to Section 41 of the Mental Health Act 1983 (England and Wales), are defined as posing a serious risk of harm to others. They are thus dealt with by forensic mental health services, which are often seen as specialists in risk assessments. This paper is based on original research in three mental health trusts in the South of England which was carried out between March 2009 and September 2011. The paper examines mentally disordered offenders' awareness and attitude to formal risk assessments in relation to theories of governmentality. Service users, subject to Section 41 of the Mental Health Act 1983 were aware that their level of risk was being assessed by professionals caring for them but were commonly unaware of the content of these assessments. These risk assessments were viewed by participants as a means through which professionals measured and monitored behaviour. Although participants often referred to levels of risk they did not view risk screening schedules as objective, but rather emphasised the need to persuade staff that their risk had reduced. Despite showing a limited awareness of the content of these risk assessments, participants generally identified more risks, in relation to their vulnerability, than did the professional assessments. However, participants generally identified fewer risks in relation to the dangers they posed to others than did professional staff.

Key words: risk, risk assessment, risk perception, risk communication, risk management, forensic mental health

Introduction

The issue of whether those with a mental disorder pose a significant risk to others has been subject of research for over 70 years (Harris and Lurigio, 2007). Whilst some conclude that a modest connection between mental disorder and violence exists (Walsh et al, 2002; Leitner et al, 2006; Burke, 2010), others argue that research findings remain disparate and inconclusive (Sirotych, 2008). Although the evidence remains contested, members of the public tend to see a strong connection between mental disorder and violence nonetheless (Stuart, 2003) and this takes on particular significance with mentally disordered offenders who may also be deemed dangerous by virtue of their offending. The increasing emphasis on risk assessment within mental health policy in the UK since the 1990s can be seen to be a response to such concerns. Whilst the literature on risk and mental health is extensive, much of this focuses on the degree to which tools of risk assessment might be considered effective or how risk assessments might be deployed by professional staff.

Research into service user views is less common (Sullivan, 2005). This paper presents original research which examines mentally disordered offenders' awareness and attitude to formal risk assessments in relation to theories of governmentality. In order that these findings can be theoretically examined, theories of governmentality are first outlined, before a summary of policy and research is given. The aims of the research and methodology employed are then described before the findings themselves are presented.

Foucault's (1991) theory of governmentality provides a useful starting point for developing an understanding of risk assessment practice within mental health

services. Foucault's theory refines his earlier theories of power / knowledge and forms part of a historical analysis into the ways in which governmental control developed in Europe. Foucault argued that from the Sixteenth and Seventeenth Century there was less focus on the conduct of the sovereign and greater concern with the management of the population. This led to new forms of governance in which monitoring and protection were achieved through, 'the ensemble formed by institutions, procedures, analyses...reflections, calculations and tactics' (Foucault, 1991, p. 102). Castel (1991) argued that psychiatry provided an example of this and that it developed as an organisational site of power through developing particular types of social control. He argued that a change occurred from one in which professionals saw danger as residing within specific individuals to one in which risk was seen as an objective entity residing within the population. Castel contended that this led to the development of an 'epidemiological clinic' in which professionals aimed to control and diminish risk through an increased focus on records and forms of control of the general population. Rose (1999) has also noted the ways in which in contemporary society individuals are not only encouraged but are compelled to manage their own risk, with those who are unwilling or unable to do so becoming the focus of professional services tasked with reducing risk.

Governmentality theory has been criticised for viewing individuals as easily manipulable by experts and for giving an underdeveloped account of human agency (Taylor Gooby and Zinn, 2006). This can result in a lack of focus on the ways that individuals may resist control. Attention therefore needs to be given to how risk policy and guidance is applied and experienced in practice. At an organisational level, both general and forensic mental health services stratify service users

according to their risk, although forensic units differ in that they include sub-systems providing higher levels of security (Kennedy, 2002). Heyman et al (2004) have likened these levels of security to a 'risk escalator'. Within this system, users are placed at the correct level of security in accordance with their assessed level of risk, although it is easier to move up to higher levels of security and surveillance than down. Whilst this is presented by managers as an ideal model, resource limitations can limit professional decision making in this respect (Heyman et al, 2004). The multi-disciplinary nature of mental health work may also affect risk decisions as the differing status of such groups may affect their ability to respond creatively to risk. Research by Godin et al (2006) noted that nurses and nursing assistants tended to be more restricted than other groups by risk protocols which sometimes required them to act in a manner that they found counter-intuitive. In addition to this different professional groups may be constrained by their own identities and regulatory structures (Luhmann, 1995). These then affect the way in which they interpret the nature of risk, although such differences are rarely made explicit in practice (Godin et al, 2007; Davies et al, 2006).

Service user views of risk are under-researched and under-theorised (Sullivan, 2005; Davies et al, 2008). Research indicates that service users do use the concept of risk to understand their situation, but that they hold different concerns to those of their care staff (Manthorpe and Alaszewski, 2000; Godin et al, 2006). Specifically, Service users held within forensic hospitals were concerned about violence from other in-patients, risks of institutionalisation, loss of family contact and detrimental effects from prescribed medications (Godin et al, 2006). Service users are acutely aware that their behaviour are regularly monitored and reported upon by staff and

that these judgements then form the basis of discharge decisions (Godin et al, 2007; Davies et al, 2008). Consequently, they may try to second guess staff assessments (Davies et al, 2008) or may avoid voicing open resistance as this may be interpreted as high risk behaviour (Coffey, 2011).

This paper uses Foucault's (1991) theory of 'governmentality' to consider mentally disordered offenders views towards 'their' risk assessments. The use of quotation marks around the word 'their' is used to indicate that whilst these assessments are written about service users, the extent to which they reflect service users views remains unclear. Governmentality theory is used in this article as a means to analyse power relations within risk assessment processes and the extent to which service users might own such practices. Whilst research within general mental health services has indicated that service users were rarely aware of such assessment (Langan and Lindow, 2004) findings may differ in forensic settings due the particular emphasis on risk that these services have. This paper therefore aims to examine both service users' level of awareness of risk assessments and their views about their purpose.

Methodology

The research in this paper forms part of a wider study conducted in three mental health trusts in the South of England between March 2009 and September 2011. The projects title for participants was 'Service User views of risk under section 41 of the Mental Health Act'. The research objectives were to analyse the way that service users subject to section 41 of the Mental Health Act 1983 (as amended by

the Mental Health Act 2007) (Department of Health 1983; 2007) (MHA) conceptualised their own risk; to identify their views and understandings toward risk assessment practice and to gain an understanding of their views toward the order itself. This article deals specifically with the issue of service user understandings and views toward risk assessment practice. The research was primarily qualitative and the processes of data collection and analysis are described below.

Sample

The key inclusion criterion for this research was that service users be subject to section 41 MHA. I focussed on this group as they have been judged by the legal system to pose a particularly high risk to others. Ethical approval was granted by the NHS National Research Ethics Service and by the research department of each Mental Health Trust. Thirty eight potential participants were approached through their care teams. Of these, nineteen agreed to take part and nineteen declined. Sampling continued until a cross section of participants had been achieved. Service users who agreed to take part gave written consent. The gender balance of participants was roughly equivalent to the restricted patient population between 1998 and 2008 where 11-13 per cent were female (MOJ, 2010). Details of participant age, ethnicity, index offence (the offence leading to the imposition of the order) and legal status are given below. Pseudonyms have been used for both participant and staff..

[Insert Table 1 here].

Data collection and analysis

Research has tended to focus on professional risk predictions with little attention being paid to the way that service users perceive their own risk. It was felt that

service users would be unlikely to want to share specific details of their offending behaviour with others and focus groups were therefore seen as inappropriate. In-depth semi-structured interviews were viewed as the most appropriate method as they enabled service users to outline their understanding and views of risk assessments on a one-to-one basis. Participants were asked about how they came to be on the order, the purpose of their Ministry of Justice conditions and whether they felt that the order affected the way in which professionals worked with them. They were also asked about the purpose of supervision and the tasks that their supervisors needed to complete as a result of this. Participants were asked whether they had ever seen a risk assessment and what they thought that its purpose was. They were asked about whether they found it fair and accurate and whether they felt that they could influence the process in any way. Interviews were transcribed and coded in order to highlight themes. Nvivo software was used to organise and code the data. Coding was undertaken at different levels of generality to avoid the problem of identifying themes that were either too general or so specific.

Given that current guidance indicates that risk assessments should be led by professionals (DOH, 2007), service users were shown a professional risk screen and asked to indicate whether they had posed any of the risks listed there either now or in the past. The risk screen was based on a tool by one Mental Health Trust and contained 55 categories of overall risk. This data was then compared against a risk screen completed by mental health professionals contained in the service user's medical and social care notes, which also recorded past and present risks. A Kappa measure of agreement was used to explore the level of agreement between service users and professionals. Data were analysed through using the Statistical Package

for Social Sciences (SPSS) version 19.

Findings

Participants' levels of awareness of risk assessment tools

The majority of participants were aware that a risk assessment about them existed. For example, Michael had been admitted to a High Secure Hospital following an incident of manslaughter. He laughed when asked whether his community mental health team had a risk assessment about him, saying: "They've got more than one probably".

Michael went on to say that he believed that staff used assessments as a means to monitor his behaviour and to prevent future offending. In joking about the amount of assessments that might exist about him, Michael was indicating the importance that risk management had for professionals working with him. In line with this response, other participants showed an understanding that they had been judged by professionals to pose an unacceptable risk to others and that their care was managed in accordance with these concerns.

However, although participants generally believed that risk assessments about them existed, awareness of the content was low. The majority stated that risk assessments had not been openly shared with them. Six of the participants stated that they had never seen a risk assessment, whilst one could not remember. Participants generally stated that they had been informed of risk judgements by professionals rather than being asked to contribute towards their construction. For example,

Oliver: Yes, I heard them talking about it, saying I am going to update your risk every so often he use to do it regularly, once a month or something like that, Steve the CPN [Community Psychiatric Nurse] who's retired now, he was in the forensic team, he used to do that.

Researcher: Did you ever get to see the thing he was updating?

Oliver: He just told me basically. He said 'you're low' and we had a meeting and he would say it then in the CPA meeting.

Whilst current government guidance implies a model in which service users are encouraged to take responsibility for risks (DOH, 2007), Oliver's account gives a scenario in which he was informed of a judgement and given little opportunity to respond to it. The rationale underlying the 'low risk' definition was not made available and he was given limited space to respond to the judgement. Similarly, most participants felt that the processes of risk definition were rarely made explicit and few were given copies of their risk assessments. There was no common view as to which professionals held responsibility for the process and participants would sometimes confuse risk assessments with other documents such as care plans.

User involvement within the assessment process

Participants who had been involved in risk assessment procedures showed a greater level of engagement with their care staff. Two participants described actively contributing towards risk assessments. Their accounts differed from other participants in that they were able to outline their own role within the procedure. Ben was the only participant who described having any involvement in the construction of his initial assessment. He described identifying potential risks with a psychologist in the following way:

Ben: ...[we discussed] noticing when I'm falling ill and what makes me go ill and what are the signs of when I'm feeling ill and we drew up a plan and how we go about it if what I want to happen if I was faced with any of them signs or any signs that I was coming out what we were going to do about it and what help I would need and what should be the outcome and should I be recalled or do I need monitoring or do I need more support and we drew up a plan and risk assessments and such.

Researcher: Did most of the ideas about risk come from you do you think?

Ben: Yes and a few from them. We agreed to disagree with theirs.

Researcher: ...You said 'we agreed to differ'. Did you feel happy with the compromises that were made?

Ben: Yes I was quite happy with that to respect their views as they are professionals at the end of the day and it's their job so I have to give it to them out of respect.

Whilst power relations between participant and professionals are not viewed to be equal in this account, Ben has shown a willingness to characterise some of his past behaviours as risks. This is in line with research that has found that risk issues take on an extra saliency for individuals where they are related to their everyday experience (Petts et al. 2001). Whilst Ben disagreed with some professional interpretations, the difference between his views and those of his team were transparent. Although his framing of the risk events differed from professional assessments he was willing to let these perspectives co-exist on the basis that professionals were acting in his best interests.

Risk measures and professional judgement

Six of the participants in the study referred to their risk being rated as 'low', 'medium' or 'high' within their interviews. For example, Ian referred to categories of risk within his own assessment.

Researcher: What would happen to the risk assessment if you didn't do any of those things [not harming himself or others]?

Ian: It would go down in stages, they have four boxes, low, moderate, high, very high and it would go down to low.

Researcher: How long before it would go down to low?

Ian: Don't know. All my life, knowing how strict these places are.

However, whilst Ian referred to his risk categorisation in probabilistic terms, this did not indicate that he believed that he was being assessed in a probabilistic manner. The way in which the processes were described implied a system based on professional judgement. Within Ian's account, categorisation was related to the hospital system being 'strict' and risk judgements was seen to be related to behavioural standards set by staff, rather than being informed by a structured process. Similarly, Quentin talked about the way that his risk categorisation had been reduced from 'high' to 'low'. He said:

It took a long time to persuade them that I wasn't going to do what they thought I was going to do, because I had been back and forwards to [the participant's home town] several times, I have been to the house where all the trouble started, I've been back to see my girlfriend, I've stayed weekends up there. That's why I said I get three nights [leave] a fortnight. So I stay there sometimes and there hasn't been no trouble so that's why the risk assessment 'as gone right down.

In stressing the importance of persuasion, Quentin was putting forward the view that assessments were constructed by staff and reflected values that they saw as desirable. Previous research (Godin et al 2007; Davies et al, 2008) indicated that forensic service users felt that they needed to convince staff that they should no longer be labelled as a 'high-risk' through predicting and mirroring their views. Similarly service users in my research described a process of complying with

professional objectives in order to lower their risk categorisation in order to gain greater freedoms. Consequently, the process of risk reduction was viewed as an inter-relational process. Quentin's account did not suggest an acceptance of staff categorisations (he continued to dispute the staff analysis), but described a need to produce behaviours that were seen as 'low risk' by them.

Levels of agreement with risk assessments

A number of participants were not sufficiently aware of the content of their risk assessment to make a judgement about its accuracy. Of those who felt sufficiently aware to comment, two fully agreed with what was written and five noted that they disagreed with some aspects. They had differing views about the reasons for their offending behaviour and appropriate strategies for managing their risk. Participants tended to be more positive about risk assessments where their perspectives of illness and treatment concurred with those of staff. However, the majority felt that professional perspectives framed which behaviours were seen to be appropriate and felt that that they had limited power to influence this. Coffey (2011; 2012b) found that mental health staff tended to see social supervision as a process of risk management and reduction. Whilst service users tended not to view supervision in these terms, they did have a sense that they were people who had 'got to be kept an eye on' (2011, p. 751). My research supports these findings in that participants tended to emphasise the high degree of monitoring that they were subject to. For example, Daniel stated,

...of course it paints you, quite properly, in your worst situation, whereas you would always like to be seen in your best situation. But that's a natural thing, because of course the whole purpose of identifying risks is to enable people in, the professions, to actually recognise

improvements...

Thus Daniel saw risk assessment as being a means through which staff developed a baseline against which they could measure his behaviour. In referring to the staff's desire to recognise improvements, Daniel showed an awareness that his behaviour was being categorised. In this case the behaviour at the time of the offence was seen as a risk marker. This behaviour was then recorded in order to allow professionals to recognise progress. The majority of participants concurred with this view, believing that risk assessments were a means through which their behaviour was categorised and graded. Within the context of the assessment, the majority saw risk as being defined as offending behaviour, signs of mental ill health or a combination of the two.

It has been suggested that service users who are detained in long stay psychiatric hospitals are conditioned into compliance (Dvoskin and Steadman 1994). However participants in this research generally felt that they were able to voice a disagreement. In some cases they felt that this might lead professionals to check the accuracy of statements. Whilst participants did not feel that they had to agree with the content of assessments, they did feel that they were forced to comply with assessment outcomes. This is illustrated in the following extract.

Researcher... did you raise the disagreement that you had, did you mention it?

Eric: I did yeah, I did mention it, but basically I couldn't do anything about it because what the team felt was necessary, I had to go along with it.

Researcher: Right.

Eric: Um, in order to stay out in the community you basically got to put up

with it and just agree.

Researcher: OK, so you don't really think that you've got the power to disagree?

Eric: No you haven't, you can voice an opinion but it wouldn't change anything.

In this extract Eric noted that whilst a disagreement might be documented, he was required to comply with the results of the assessment. Eric, like several other participants, disagreed with the outcome of the assessment which suggested that he required further monitoring and supervision. Within Eric's account disagreements were seen as unlikely to lead to a change in staff position, but rather emphasised the level of difference between parties. As a consequence of this, some participants saw risk assessments as a means by which professionals justified continued supervision.

Comparisons of service user and professional ratings of risk

Whilst previous research has examined the way in which service users subject to section 41 conceptualise their own risk both in hospital (Godin et al 2007; Davies et al, 2008) and in the community (Coffey, 2011;2012a; 2012b), there is a lack of knowledge as to how service users might rate their level of risk when presented with professional risk screening schedules. This paper addresses this gap.

Table 2 indicates the level of agreement between service users and professionals about the level of risk. A Kappa score > 0.75 was taken to indicate excellent agreement, $0.4 - 0.75$ indicated a fair to good agreement and < 0.4 was seen to represent poor agreement (Kirkwood and Sterne, 2003). Kappa scores for each participant are described in Table 2 below. Poor levels of agreement between

service users and professionals were found in 14 cases and a fair to moderate level of agreement in five cases. It was not possible to conduct Kappa tests within sub-categories of risks within the risk screen (such as risk of self harm or risk to others) as total agreement occurred between service users and staff in some cases.

Although the level of agreement between service users and staff was generally low, service users often identified areas of risk that had not been raised by staff. The range of risks identified by service users but not by staff ranged between 1 and 27, with the mean number being 10.79. Participants generally identified more risks than professionals. However, this fluctuated between categories of risk.

[Table 2 here]

When participants were asked about whether they had ever neglected themselves, most participants identified more risks than staff. The risk screen that the service users were asked to complete contained 6 categories of risk listed under the heading of self-neglect. In regard to these, the total amount of risks identified by all service users combined was 31, whereas the total amount of risks identified by professionals combined was 20. This trend was also present when research participants were asked about suicide and self harm, with the majority of participants highlighting more risks than professionals. The risk screen that was presented to participants had 4 categories of risk listed under suicide and self harm. The total amount of risks by all service users combined in this area was 39, whereas the total amount of risks identified by staff was 33. In contrast to these results participants had a tendency to identify fewer risks when asked to identify whether they had ever posed a risk of harm to others. In this case, the trend was reversed with professionals identifying more risks than service users. The risk screen that was presented to research participants contained 9 items under the heading of Risk to Others. The number of risks identified by all service users combined was 87 whilst the number of risks identified by all professionals combined was 102.

Ryan (2000) has suggested that mental health service users do not convey risks in the same way as staff, due to not having access to the same language. This research has shown that when presented with a risk screen, service users were more likely than professionals to identify a wider range of risks stressing their vulnerability rather than their danger to others. This is in line with previous mental

health research which has noted that whilst service users may share professional perspectives of risk, they are more likely to identify risks from treatments (such as side effects from medications) (Manthorpe and Alaszewski, 2000; Godin et al, 2006). However, my research also indicates that service users in this study were less likely to highlight risks to others than professional staff. The implications of these results will be discussed below.

Discussion

The study which underpins this paper had its limitations. The sample for this research was small and the statistics therefore illustrate their views rather than being representative of the wider population. However, the results do build on the findings of previous research. Unlike participants in Langan and Lindow's study (2004), participants in my research were generally aware that risk assessments about them existed. However, they were often unaware of the contents of these assessments and reported a low level of involvement in their construction.

Governmentality theorists argue that although professionals are tasked with identifying and minimising risk, citizens are also encouraged to minimise risk at an individual level. Government can be seen to advocating user involvement in this way within mental health services (DOH, 2007). However, service users in this study did not feel that risk assessments provided them with the means to understand and reduce their risk with the majority stating that assessments were constructed without their involvement. Olafsdorrit argues that theories of power rest on notions of who is permitted to, 'define, describe and respond to various social behaviours' (2011, p. 241). Service users in this study felt that they had a limited degree of power to

influence risk assessments. Research participants noted that they were normally excluded from initial formulations of risk. Consequently, problems were largely framed within professional terms and medical perspectives tended to dominate. This is not to suggest that all service users wished to reject medical perspectives entirely. In line with previous research (Coffey, 2012), many participants believed that their offending had come about as a result of mental disorder and referred to this as a mitigating factor. However, a lack of involvement at the initial stages of assessment did limit participants opportunities to define risks in their own terms or even to indicate where their concerns lay. As with mentally disordered offenders in other studies (Godin et al, 2006; Godin et al, 2007; Davies et al, 2008), research participants believed that staff concerns focussed around issues of treatment compliance. Risk assessments were seen as a means of systemising these concerns. Consequently, they viewed risk assessments primarily as bureaucratic tools that identified risk markers for the benefit of professionals.

Although risk assessments were seen as bureaucratic tools, they were not viewed as systematic but rather were seen to reflect what Rose (2000) refers to as a particular gaze. When describing risk assessments, participants referred to probabilistic terms (such as high, medium or low risk). This was in line with observations by de Swann (1990) that service users increasingly use professional terms to describe their own problems. However, although service users referred to these terms, they tended to view assessments as being formed by professional opinion rather than by statistical measures. Whilst participants felt able to challenge assessments, such challenges were seen as unlikely to alter assessment outcomes. This tended to result in participants either taking a passive role or as with participants in Davies et al's

research (2008), feeling that they needed to mirror staff views in order change the contents of their assessments.

Risk research outside of mental health has indicated that 'lay-people' may frame risks more widely than 'risk-experts' through adopting a wider frame of, 'topics, considerations and agendas' (Horlick-Jones, 2005, p. 259). The tendency of service users to identify more risks within this study than staff did in their risk assessments may be as a result from a wider interpretation of risk, although this process is not straightforward. Risk screening schedules pose specific questions which may not allow for the identification of all risks (for example, the screen did not ask service users to identify side-effects from medication). However, even within the risk categories presented, there was scope for service users to interpret these more widely than professionals and this may account for a level of difference.

Alternatively, the difference may be due to service users holding a greater knowledge about their personal circumstances. The findings also indicate that participants tended to identify less risk to others than professionals. This might indicate a tendency for participants to convey their risk in ways which identify them as morally good. However, it might also indicate a tendency for professionals to pay more attention to this category of risk. These differences in risk perceptions point to the need for greater attention to be paid to the way in which service users conceptualize and define their own risks throughout the risk assessment process.

Conclusion

Service users subject to section 41 of the MHA have committed serious offences and are therefore subject to forms of control which are defined through legislation, policy and professional cultures. This paper has shown that service users subject to section 41 MHA were aware that risk was viewed as an important concept by professionals, but were largely unaware of the contents of their risk assessments. In exceptional cases, research participants gave accounts in which they had been involved in the construction of risk assessments and these participants expressed greater satisfaction with the process. Risk assessments were largely viewed as a tool that was utilised by professionals in order to monitor and manage their risk according to professional priorities. Whilst participants were often aware that these assessments contained risk measures, these categorizations were not viewed as actuarial but were instead seen to reflect professional values. When presented with a professional risk screen, participants generally identified more risks in relation to their vulnerability than did professional assessments. However, participants generally identified fewer risks in relation to the dangers they posed to others than did professional staff.

Table 1

Details of Research Participants

Pseudonym of Participant	Gender	Age	Ethnicity	Index Offence	Legal Status
Adam	Male	35	White UK	Manslaughter	Conditional discharge
Ben	Male	39	Black British	Assault and Actual Bodily Harm	Conditional Discharge
Christopher	Male	53	White UK	Actual Bodily Harm	Conditional Discharge
Daniel	Male	59	White UK	Manslaughter	Conditional Discharge
Eric	Male	40	White UK	Arson	Deferred Conditional Discharge (after having been recalled from a Conditional Discharge)
Francis	Male	45	White UK	Actual bodily harm and criminal damage	Conditional Discharge
Grace	Female	45	White UK	Arson	Conditional Discharge
Henry	Male	55	White UK	Arson and burglary	Conditional Discharge
Ian	Male	36	White UK	Actual bodily harm	Detained under s. 37/41 MHA (after having been recalled from a Conditional Discharge)
Lamal	Male	26	Somali	Actual Bodily Harm	Detained in hospital under s. 37/41 MHA.
Michael	Male	52	Jamaican	Manslaughter	Conditional Discharge
Neil	Male	38	Black British	Manslaughter	Conditional Discharge
Oliver	Male	49	White UK	Sexual offence	Conditional Discharge
Phillip	Male	31	White UK	Malicious wounding	Conditional Discharge
Quentin	Male	47	White UK	Actual Bodily Harm	Conditional Discharge
Richard	Male	34	Polish	Wounding with intent to assault	Conditional Discharge
Sally	Female	39	White UK	Affray and Criminal damage	Conditional Discharge
Tony	Male	35	White UK	Common assault	Conditional Discharge
Vic	Male	36	White UK	Actual Bodily Harm	Deferred Conditional Discharge

Table 2

Summary of service users and professional ratings of all risk categories

Participant number	Service user and professional agree about presence or absence of risk	Risk identified by service user only	Risk Identified by professional only	Kappa statistic
1	32	7	16	0.17
2	35	10	1	0.36
3	39	7	9	0.39
4	38	1	16	0.24
5	37	13	5	0.36
6	42	4	9	0.46
7	42	10	3	0.53
8	27	27	1	0.17
9	40	11	4	0.46
10	36	4	15	0.29
11	29	14	12	0.04
12	39	12	4	0.39
13	29	22	4	0.10
14	40	12	3	0.32
15	38	14	3	0.40
16	45	9	1	0.60
17	45	7	3	0.65
18	39	5	11	0.30
19	38	16	1	0.20
Total	719 (68.8%)	205 (19.6%)	121 (11.6%)	

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